STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00095233. Complaint IN00095233 - Substantiated. Federal/State deficiency related to the allegation is cited at F282. Survey dates: August 30 and 31, 2011 Facility number: 000057 Provider number: 155132 AIM number: 100266570 Survey team: Connie Landman RN Census bed type: SNF: 13 SNF/NF: 80 Total: 93 Census payor type: Medicare: 17 Medicaid: 60 Other: 16 Total: 93 Sample: 4 This deficiency cited also reflects State findings in accordance with 410 IAC 16.2. Quality review completed 9/7/11 by	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Jennie Bartelt, RN.			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician's orders were followed to send an ill resident to the hospital for 1 of 4 residents reviewed for physicians' orders in a sample of 4 (Resident D). Findings include: The record for Resident D was reviewed on 8/31/11 at 8:45 A.M. Current diagnoses included, but were not limited to, paralysis, pressure ulcer to buttocks, diabetes mellitus type 2, hyperlipidemia, partial arterial occlusion, hypertension, trans cerebral ischemia, aortic atherosclerosis, and paraplegia. Resident D was admitted to the facility on 8/1/11 in the late evening. Nursing notes at that time, indicated the resident's B/P (blood pressure) was 146/93, and his HR (heart rate) was 97, he had no complaints of pain. The notes also indicated the resident was alert and confused but could verbalize his wants and needs.	F0282	We are cordially requesting a desk review for survey event XVOX11.Corrective action: Resident was sent to the hospital per MD ordersOther residents having the potential to be affected: all new orders are taken to daily clinical review Monday - Friday (excluding holidays).Systematic changes: Chart checks will be completed every 24 hours to ensure that new orders are followed. Inservice was completed on 9/15/11 reviewing systematic changes.Monitoring: 24 hour chart check forms with be collected daily by DON or designee,Monday - Friday (excluding holidays). Random chart checks will be completed weekly x 4, monthly x 2 and quarterly. Results will be brought and reviewed at the Quality assurrance meetings.Date of completion: 9-23-11	09/23/2011

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Nursing Notes on 8/3/11 at 5:30 A.M. indicated the physician was called and a message was left notifying him of a change in mental status and B/P 128/98 and HR 135.

The next untimed nursing entry indicated the physician returned the call and was updated on the resident's vital signs and condition through the night. The entry indicated the physician gave the order at that time to send the resident to the hospital.

The physician's orders indicated the order to send the resident to the hospital ER was written at 6:11 A.M. on 8/3/11. A line had been drawn through this order with the word "void" over the top of the order.

The next Nursing Note, dated 8/3/11, untimed, indicated the DON (Director of Nursing) was notified of the order to send the resident to the ER. The note indicated the DON was informed of the change in condition and vital signs throughout the night. The note indicated the DON advised the nurse to monitor the resident for an hour and to give B/P medication and pain medication that A.M., and after that re-evaluate the order to send the resident to the hospital.

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	The next Nursing Note entry was dated 8/3/11 at 6:20 A.M. The entry indicated: "Writer called (physician's name).et (and) advised DON (name) stated 'not to send res (resident) to hospital at this time need to monitor closely.' (Physician's name) stated 'its her malpractice lawsuit.'" The resident was monitored in the facility throughout the day, receiving intravenous fluids and additional pain medication which had been ordered by the physician at 9:30 A.M.. His B/P and HR were monitored and at times could not be taken due to flailing of the resident's arms and combativeness, indicated in the Nurses Notes on 8/3/11 at 1:00 P.M. No evening shift documentation was recorded until 10:00 P.M., which indicated the resident had been sent to the hospital emergency room earlier due to restlessness, flailing, trying to get out of bed, and combativeness. When the family came in, no arrival time noted, they requested the resident go to the hospital, and the order was received and the resident was sent. A new physician's order to send the resident to the hospital was written 8/3/11 at 6:30 P.M. A Nurses Note at 11:00 P.M., 8/3/11, indicated the resident had been admitted to the hospital with sepsis and altered			

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	mental status. During an interview on 8/3/11 at 9:00 A.M., the Unit Manager indicated the resident had had a change in condition from the day before, and he did want the resident to go to the hospital, but did as the DON had requested. The Unit Manager had called the physician back that morning to inform him of the DON's response to the order to send the resident out. The Unit Manager indicated the staff had monitored the resident closely and administered the morphine pain medication as the physician ordered and the DON wanted it to be given until the evening when, because the resident was sleeping quietly, the medication had not been given hourly, and the resident again displayed distress and was sent to the hospital at the family's request. During an interview on 8/3/11 at 9:40 A.M., the DON indicated she felt the staff hadn't given the resident his pain medication through the night, and the facility would be able to care for him appropriately after they had his pain under control. She indicated she felt the elevated B/P and HR were due to pain and this would be the way to treat him, and he did calm down and rest once he had been receiving the morphine routinely.			

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	3.1-35(g)(2)			